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515.001: Definition of Terms

The terms listed in 130 CMR 515.001 have the following meanings for purposes of MassHealth, as described in 130 CMR 515.000 through 522.000.

Activities of Daily Living (ADLs) — self-care activities including, but not limited to, bathing, grooming, dressing, eating, and toileting.

Affidavit — a written or printed statement of fact sworn to or affirmed before a person having legal authority to administer such an oath.

Annuity — a legal instrument that pays a fixed sum in regular, periodic installments for a designated period of time, or for life.

Appeal — a written request, by an aggrieved applicant or member, for a fair hearing.

Appeal Representative — a person who:

(1) is sufficiently aware of the appellant's circumstances to assume responsibility for the accuracy of the statements made during the appeal process, and who has provided the Board of Hearings with written authorization from the appellant to act on the appellant's behalf during the appeal process;

(2) has, under applicable law, authority to act on behalf of an appellant in making decisions related to health care or payment for health care. An appeal representative may include, but is not limited to, a guardian, conservator, executor, administrator, holder of power of attorney, or health-care proxy; or

(3) is an eligibility representative meeting the requirements of (1) or (2) above.

Applicant — a person who completes and submits an application for MassHealth, and is awaiting the decision of eligibility.

Application — see "MassHealth Application."

Asset Limit — the maximum dollar value of assets that can be owned by, or available to, the applicant, member, or the spouse, which if exceeded, results in ineligibility.

Assets — property including, but not limited to, real estate, personal property, and funds. This term has the same meaning as "resources" as defined in 42 U.S.C. 1396p(e)(5).

Available — a resource that is countable under Title XIX of the Social Security Act.

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Blindness — a visual impairment as defined in Title XVI of the Social Security Act. Generally, “blindness” means visual acuity with correction of 20/200 or less in the better eye, or a peripheral field of vision contracted to a 10-degree radius or less, regardless of the visual acuity.

Burial Trust — a trust established by an individual solely for funeral expenses, burial expenses, or both.

Business Day — any day during which MassHealth’s offices are open to serve the public.

Caretaker Relative — an adult who is the primary caregiver for a child, is related to the child by blood, adoption, or marriage, or is a spouse or former spouse of one of those relatives, and lives in the same home as that child, provided that neither parent is living in the home.

Case File — the permanent written collection of documents and information required to determine eligibility and to provide benefits to applicants and members.

Community Resident — a person who lives in a noninstitutional setting in the community.

Competent Medical Authority — a physician or psychiatrist licensed by any state, a psychologist licensed by the Commonwealth of Massachusetts, or both.

Countable Income — the types of income that are considered in the determination of eligibility.

Countable-Income Amount — gross income less certain business expenses and income deductions.

Couple — two persons married to each other according to the rules of the Commonwealth of Massachusetts.

Coverage Date — the date medical coverage begins.

Coverage Types — a scope of medical services, other benefits, or both that are available to members who meet specific eligibility criteria. These coverage types include the following: MassHealth Standard (Standard), MassHealth Essential (Essential), MassHealth Limited (Limited), MassHealth Senior Buy-In (Senior Buy-In), and MassHealth Buy-In (Buy-In). The scope of services or covered benefits for each coverage type is found at 130 CMR 450.105.

Curing of a Transfer — the return, following the transfer for less than fair-market value of a portion of, or the full uncompensated value of, a resource to the individual.

Day — a calendar day unless a business day is specified.

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Deductible — the total dollar amount of incurred medical expenses that an applicant whose income exceeds MassHealth income standards at 130 CMR 520.028 et seq. must be responsible for before the applicant is eligible for MassHealth.

Deductible Period — a specified six-month period within which an applicant for MassHealth, whose income exceeds MassHealth income standards, may become eligible if the applicant or the spouse incurs medical bills equaling or exceeding the deductible.

Disability Determination Unit — a unit that consists of physicians and disability evaluators who determine permanent and total disability using criteria established by the Social Security Administration under Title XVI, and criteria established under state law. This unit may be a part of a state agency or under contract with a state agency.

Eligibility Process — activities conducted for the purpose of determining, redetermining, and maintaining the eligibility of a MassHealth applicant or member.

Eligibility Representative — a person who:

- (1) has, under applicable law, authority to act on behalf of an applicant or member in making decisions related to health care or payment for health care. An eligibility representative may include, but is not limited to, a guardian, conservator, executor, administrator, holder of power of attorney, or health-care proxy; or
- (2) is sufficiently aware of the applicant's or member's circumstances to assume responsibility for the accuracy of the statements made during the eligibility process, and who fulfills at least one of the following two conditions:
 - (a) has provided the Division with written authorization from the applicant or member to act on the applicant's or member's behalf during the eligibility process; or
 - (b) is acting responsibly on behalf of an applicant or member for whom written authorization cannot be obtained.

Fair Hearing — an administrative, adjudicatory proceeding conducted according to 130 CMR 610.000 to determine the legal rights, duties, benefits, or privileges of applicants and members.

Fair-Market Value — an estimate of the value of a resource if sold at the prevailing price. For transferred resources, the fair-market value is based on the prevailing price at the time of transfer.

Federal Poverty Level (FPL) — income standards issued annually in the *Federal Register* to account for the last calendar year's increase in prices as measured by the Consumer Price Index.

Fee-for-Service — a method of paying for medical services provided by any MassHealth participating provider with no limit on provider choice.

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Global Developmental Skills — a child's average developmental skill level, taking into account the physical, psychological, motor, intellectual, emotional, communicative, and social aspects of the child's functional capabilities.

Grantor — an individual or spouse who creates a trust.

Gross Income — the total money earned or unearned, such as wages, salaries, rents, pensions, or interest, received from any source without regard to deductions.

Guardian — an individual or entity appointed as guardian by the probate and family court under the provisions of M.G.L. c. 201.

Guardianship Fees and Related Expenses — fees for guardianship services and incurred expenses that are essential to enable an incompetent applicant or member to gain access to or consent to medical treatment.

Income Deductions — specified deductions, as described in 130 CMR 520.011 through 520.014, that may be made from the gross income of an applicant or member.

Incompetent Applicant or Member — an applicant or member who has been adjudicated as incompetent and in need of a guardian by the probate and family court under the provisions of M.G.L. c. 201.

Individual — an applicant, a member, a spouse who is acting on behalf of the applicant or member, or any person, court, or administrative body with the legal authority to act on behalf of or at the request of the applicant, member, or spouse and may include a trustee, guardian, conservator, or an agent acting under a durable power of attorney.

Institution (Medical) — a public or private facility providing acute, chronic, or long-term care, unless otherwise defined within 130 CMR 515.000 through 522.000. This includes acute inpatient hospitals, licensed nursing facilities, state schools, intermediate-care facilities for the mentally retarded, public or private institutions for mental diseases, freestanding hospices, and chronic-disease and rehabilitation hospitals.

Institutionalization — placement of an individual in one or more medical institutions, where placement lasts or is expected to last for a continuous period of at least 30 days.

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Interpreter — a person who translates for an applicant or member who has limited English proficiency or a hearing impairment.

Irrevocable Trust — a trust that cannot be in any way revoked by the grantor.

Jointly Held Resources — resources that are owned by an individual in common with another person or persons in a joint tenancy, tenancy-in-common, or similar arrangement.

Life Estate — a life estate is established when all of the remainder legal interest in a property is transferred to another, while the legal interest for life rights to use, occupy, or obtain income or profits from the property is retained.

Limited English Proficiency — an inadequate ability to communicate in the English language.

Look-Back Period — a period of consecutive months that the Division may review for transfers of resources to determine if a period of ineligibility for payment of nursing-facility services should be imposed.

Lump-Sum Income — a one-time payment, such as an inheritance or the accumulation of recurring income.

MassHealth Application — a form prescribed by the Division that has been completed by the applicant or an eligibility representative, and submitted to the Division as a request for MassHealth benefits. An application ceases to be an application when it is denied and not appealed.

Medical Benefits — payment for medical services provided to a MassHealth member.

Member — a person determined by the Division to be eligible for MassHealth.

Nursing-Facility Resident — an individual who is a resident of a nursing facility, is a resident in any institution, including an intermediate-care facility for the mentally retarded (ICF/MR), for whom payment is based on a level of care equivalent to that received in a nursing facility, is in an acute hospital awaiting placement in a nursing facility, or lives in the community and would be institutionalized without community-based services provided in accordance with 130 CMR 519.007(B).

Patient-Paid Amount — the amount that a member in a long-term-care facility must contribute to the cost of care under the laws of the Commonwealth of Massachusetts.

Period of Ineligibility — the period of time during which the Division denies or withholds payment for nursing-facility services because the individual has transferred resources for less than fair-market value.

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Permanent and Total Disability — a disability as defined under Title XVI of the Social Security Act or under applicable state laws.

(1) For Adults and 18-Year-Olds.

(a) The condition of an individual, aged 18 or older, who is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment that:

(i) can be expected to result in death; or

(ii) has lasted or can be expected to last for a continuous period of not less than 12 months.

(b) For purposes of this definition, an individual aged 18 or older is determined to be disabled only if his or her physical or mental impairments are of such severity that the individual is not only unable to do his or her previous work, but cannot, considering age, education, and work experience, engage in any other kind of substantial gainful work that exists in the national economy, regardless of whether such work exists in the immediate area in which the individual lives, whether a specific job vacancy exists, or whether the individual would be hired if he or she applied for work. "Work that exists in the national economy" means work that exists in significant numbers, either in the region where such an individual lives or in several regions of the country.

(2) For Children Under Age 18. The condition of an individual under the age of 18 who has any medically determinable physical or mental impairment, or combination of impairments, that causes marked and severe functional limitations, as defined in Title XVI of the Social Security Act, and can be expected to cause death or can be expected to last for a continuous period of not less than 12 months. Disability for children eligible for MassHealth CommonHealth under 130 CMR 519.012(B) is determined in accordance with the definition for permanent and total disability for children under the age of 18 in 130 CMR 501.001.

Personal Needs Allowance (PNA) — the designated portion of monthly income that a person in long-term care is allowed to retain for personal expenses. In some instances, the Division pays all or a portion of the PNA to the member. The PNA must not be used for payment of any item included in the daily rate at the long-term-care facility.

Personal Needs Allowance (PNA) Account — an account administered by a long-term-care facility on behalf of a member. Regulations regarding the administration of PNA accounts are contained in 130 CMR 456.000.

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Pooled Trust — A pooled trust is one that meets all the following criteria as determined by the Division.

- (1) The trust was created by a nonprofit organization.
- (2) A separate account is maintained for each beneficiary of the trust, but the assets of the trust are pooled for investment and management purposes.
- (3) The account in a pooled trust was created for the sole benefit of the individual by the individual, the individual's parents or grandparents, or by a legal guardian or court acting on behalf of the individual.
- (4) The trust provides that the Commonwealth of Massachusetts will receive amounts remaining in the account upon the death of the individual up to the amount paid by the Division for services to the individual. The trust may retain reasonable and appropriate amounts as determined by the Division.
- (5) The individual was disabled at the time his or her account in the pool was created.

Quality Control — a system of continuing review to measure the accuracy of eligibility decisions.

Reapplication — the Division's reopening of the application process when the application has been denied pursuant to 130 CMR 516.001(D).

Redetermination — a review of a member's circumstances to establish whether he or she remains eligible for benefits.

Resources — all income and assets owned by the individual or the spouse. For the purposes of determining eligibility, resources include income and assets to which the individual or the spouse is or would be entitled whether or not they are actually received. This term has the same meaning as "assets" as defined in 42 U.S.C. 1396p(e)(1).

Reverse Mortgage — a loan on the equity value of a house paid in installments by a lender to the homeowner who is aged 60 or older.

Revocable Trust — a trust whose terms allow the grantor to take action to regain any of the property or funds in the trust.

Skilled-Nursing Services — the planning, provision, and evaluation of goal-oriented nursing care that requires specialized knowledge and skills acquired under the established curriculum of a school of nursing approved by a board of registration in nursing. Such services include only those services that must be provided by a registered nurse, a licensed practical nurse, or a licensed vocational nurse.

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Special-Needs Trust — a special-needs trust is one that meets all the following criteria as determined by the Division.

- (1) The trust was created for a disabled individual under the age of 65.
- (2) The trust was created for the sole benefit of the individual by the individual's parent, grandparent, legal guardian, or a court.
- (3) The trust provides that the Commonwealth of Massachusetts will receive amounts remaining in the account upon the death of the individual up to the amount paid by the Division for services to the individual.
- (4) When the member has lived in more than one state, the trust must provide that the funds remaining upon the death of the member are distributed to each state in which the member received Medicaid based on each state's proportionate share of the total amount of Medicaid benefits paid by all states on the member's behalf.

Spouse — a person married to the applicant or member according to the laws of the Commonwealth of Massachusetts.

Stream of Income — income received on a regular basis.

Substantial Gainful Activity — generally, employment that provides a set amount of gross earnings as determined by the Social Security Administration (SSA) under Title XVI of the Social Security Act.

Supplemental Security Income (SSI) Program — a program that provides financial assistance to needy persons who are aged 65 or older, blind, or disabled. This program is established under Title XVI of the Social Security Act and is administered by the Social Security Administration. Such persons automatically receive MassHealth through the Division of Medical Assistance.

Third Party — any individual, entity, or program that is or may be responsible to pay all or part of the expenditures for medical benefits.

Trust — a legal device satisfying the requirements of state law that places the legal control of property or funds with a trustee. It also includes, but is not limited to, any legal instrument, device, or arrangement that is similar to a trust, including transfers of property by a grantor to an individual or a legal entity with fiduciary obligations so that the property is held, managed, or administered for the benefit of the grantor or others. Such arrangements include, but are not limited to, escrow accounts, pension funds, and similar devices as managed by an individual or entity with fiduciary obligations.

Trustee — any individual or legal entity that holds or manages a trust.

Uncompensated Value — the difference between the fair-market value of the resource or interest in the resource at the time of transfer less any outstanding debts and the actual amount the individual received for the resource. The Division uses the uncompensated value in the calculation of the period of ineligibility.

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515.002: Introduction to MassHealth

(A) MassHealth administers and is responsible for the delivery of health-care services to its members.

(B) 130 CMR 515.000 through 522.000 (referred to as Volume II) provide the requirements for noninstitutionalized persons aged 65 or older, institutionalized persons of any age, persons who would be institutionalized without community-based services, as defined by Title XIX of the Social Security Act and authorized by Massachusetts General Laws (M.G.L.) c. 118E, and certain Medicare beneficiaries. These regulations are intended to conform to all applicable federal and state laws and will be interpreted accordingly.

(C) The requirements for coverage of noninstitutionalized low- and moderate-income persons under age 65, as prescribed under a 1115 Medicaid Research and Demonstration Waiver, are described in 130 CMR 501.000 through 508.000.

515.003: MassHealth Coverage Types

(A) MassHealth provides access to health care by determining eligibility for the coverage types that provide the most comprehensive benefits for a person who may be eligible. Generally, members are provided services on a fee-for-service basis as defined at 130 CMR 515.001.

(B) MassHealth offers the following types of coverage: MassHealth Standard, MassHealth Essential, MassHealth Limited, MassHealth Senior Buy-In, and MassHealth Buy-In. The type of coverage for which a person is eligible is based on the person's or the spouse's income and assets, as described in 130 CMR 519.000 and 520.000, and immigration status, as described in 130 CMR 518.000.

(C) MassHealth may limit the number of people who can be enrolled in MassHealth Essential. When MassHealth imposes such a limit, no new applicants aged 65 or older who are subject to these limitations will be added to MassHealth Essential, and current MassHealth Essential members who have lost eligibility for more than 30 days for any reason will not be allowed to reenroll until MassHealth is able to reopen enrollment for adults.

(1) Applicants who cannot be enrolled under MassHealth Essential pursuant to 130 CMR 515.003(C), will be placed on a waiting list when their eligibility has been determined. When MassHealth is able to open enrollment for adult applicants, the applications will be processed in the order they were placed on the waiting list.

(2) Medical coverage for MassHealth Essential for persons enrolled from a waiting list will begin on the date that the application or new determination is processed from the waiting list.

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515.004: Administration of MassHealth

(A) MassHealth. MassHealth formulates requirements and determines eligibility for all MassHealth coverage types.

(B) Other Agencies.

(1) Department of Transitional Assistance (DTA). The Department of Transitional Assistance administers the Emergency Aid for the Elderly, Disabled and Children (EAEDC) Program. Persons receiving EAEDC who are 65 or older are automatically eligible for MassHealth Standard coverage, if they meet the citizen and immigration rules for MassHealth Standard at 130 CMR 518.002. Aliens with special status described in 130 CMR 518.002(D) who are receiving EAEDC who are aged 65 or older are automatically eligible for MassHealth Essential coverage pursuant to 130 CMR 515.003(C).

(2) Social Security Administration (SSA). District Social Security offices administer the Supplemental Security Income (SSI) Program and determine the eligibility of persons aged 65 or older. Persons receiving SSI who are 65 or older are automatically eligible for MassHealth Standard coverage.

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Persons who are receiving public assistance from another state are not eligible for MassHealth.

515.006: Massachusetts Commission for the Blind.

Persons who are blind and aged 65 or older or institutionalized may apply for MassHealth with the Massachusetts Commission for the Blind (MCB).

515.007: Rights of Applicants and Members

The policies of MassHealth are administered in accordance with federal and state law. Applicants and members must be informed of their rights and responsibilities with respect to MassHealth.

(A) Right to Nondiscrimination and Equal Treatment. The Division of Medical Assistance does not discriminate on the basis of race, color, sex, sexual orientation, religion, national origin, disability, or age in admission or access to, or treatment or employment in, its programs or activities. Grievance procedures for resolution of discrimination complaints are administered and applied by the Division's Affirmative Action Office.

(B) Right to Confidentiality. The confidentiality of information obtained by the Division during the MassHealth eligibility process is protected in accordance with federal and state regulations. The use and disclosure of information concerning applicants, members, and legally liable third parties is restricted to purposes directly connected to the administration of MassHealth as governed by state and federal law.

(C) Right to Timely Provision of Benefits. Eligible applicants and members have the right to the timely provision of benefits, as defined in 130 CMR 516.000.

(D) Right to Information. Persons who inquire about MassHealth, either orally or through a written request, have the right to receive information about medical benefits, coverage type requirements, and their rights and responsibilities as applicants and members of MassHealth.

(E) Right to Apply. Any person, individually or through an eligibility representative, has the right, and must be afforded the opportunity without delay, to apply for MassHealth.

(F) Right to be Assisted by Others.

(1) The applicant or member has the right to be accompanied and represented by an eligibility representative during the eligibility process, and by an appeal representative during the appeal process. The Division must provide copies of all eligibility notices to an applicant's or member's eligibility representative, and must provide copies of all documents related to the fair hearing process to an applicant's or member's appeal representative.

(2) An application for MassHealth may be filed by an eligibility representative on behalf of a deceased person.

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(3) An appeal on behalf of a deceased person may be filed by an appeal representative, as defined in 130 CMR 515.001.

(G) Right to Inspect the MassHealth Case File. The applicant or member has the right to inspect information in his or her MassHealth case file and contest the accuracy of the information.

(H) Right to Appeal. The applicant or member has the right to appeal and request a fair hearing as the result of any adverse action or inaction taken by MassHealth. The request will not be granted if the sole issue is a federal or state law requiring an automatic change adversely affecting members.

(I) Right to Interpreter Services. MassHealth will inform applicants and members of the availability of interpreter services. Unless the applicant or member chooses to provide his or her own interpreter services, MassHealth will provide either telephonic or other interpreter services whenever:

(1) the applicant or member who is seeking assistance from MassHealth has limited English proficiency or sensory impairment and requests interpreter services; or

(2) MassHealth determines such services are necessary.

(J) Right to a Certificate of Creditable Coverage Upon Termination of MassHealth. MassHealth provides a Certificate of Creditable Coverage to members whose coverage under MassHealth Standard, CommonHealth, Essential, or Basic has ended. MassHealth issues a Certificate to members within one week of their MassHealth termination, or within one week of the request for a Certificate, as long as the request is made within 24 months of their MassHealth termination. The Certificate may allow members to waive or reduce the length of preexisting-condition waiting periods when they enroll in a new health plan offered by private insurance. If a member's MassHealth termination also terminates the coverage of his or her dependents, the dependents are included on the Certificate.

515.008: Responsibilities of Applicants and Members

(A) Responsibility to Cooperate. The applicant or member must cooperate with MassHealth in providing information necessary to establish and maintain eligibility, and must comply with all the rules and regulations of MassHealth, including recovery.

(B) Responsibility to Report Changes. The applicant or member must report to MassHealth, within 10 days or as soon as possible, changes that may affect eligibility. Such changes include, but are not limited to, income, assets, inheritances, gifts, transfers of and proceeds from the sale of real or personal property, distributions from or transfers into trusts, address, the availability of health insurance, immigration status, and third-party liability.

(C) Cooperation with Quality Control. The Quality Control Division periodically conducts an independent review of eligibility factors in a sampling of case files. When a case file is selected for review, the member must cooperate with the representative of Quality Control. Cooperation includes, but is not limited to, a personal interview and the furnishing of requested information. If the member does not cooperate, MassHealth benefits may be terminated.

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515.009: Referrals to Investigative Units

Intentional false statements or fraudulent acts made in connection with obtaining medical benefits or payments under MassHealth are punishable under M.G.L. c. 118E § 39 by fines, imprisonment, or both. In all cases of suspected fraud, Division staff will make a referral to the Bureau of Special Investigations, or other appropriate agencies.

515.010: Recovery of Overpayment of Benefits

The Division has the right to recover payment of benefits to which the member was not entitled at the time the benefit was received, regardless of who was responsible and whether or not there was fraudulent intent. No provision under 130 CMR 515.011 will limit the Division's right to recover overpayments.

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515.011: Estate Recovery

(A) Introduction.

(1) MassHealth will recover the amount of payment for medical benefits correctly paid from the estate of a deceased member. Recovery is limited to payment for all services that were provided:

(a) while the member was 65 or older; except, on or after October 1, 1993, while the member was aged 55 or older; or

(b) on or after March 22, 1991, while the member, regardless of age, was institutionalized, and MassHealth determined that the member could not reasonably be expected to return home.

(2) The estate includes all real and personal property and other assets in the member's probate estate.

(B) Exception. No recovery for nursing facility or other long-term-care services may be made from the estate of any person who:

(1) was institutionalized;

(2) notified MassHealth that he or she had no intent of returning home; and

(3) on the date of admission to the long-term-care institution, had long-term-care insurance that met the requirements of 130 CMR 515.014 and the Division of Insurance regulations at 211 CMR 65.09(1)(e)(2).

(C) Deferral of Estate Recovery. Recovery will not be required until after the death of a surviving spouse, if any, or while there is a surviving child who is under 21 years of age, or a child of any age who is blind or permanently and totally disabled.

(D) Waiver of Estate Recovery Due to Hardship.

(1) For claims presented on or after November 15, 2003, recovery will be waived if:

(a) a sale of real property would be required to satisfy a claim against the member's probate estate; and

(b) an individual who was using the property as a principal place of residence on the date of the member's death meets all of the following conditions:

(i) the individual lived in the property on a continual basis for at least one year immediately before the now-deceased member became eligible for MassHealth or other assistance and continues to live in the property at the time MassHealth first presented its claim for recovery against the deceased member's estate;

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(ii) the individual has inherited or received an interest in the property from the deceased member's estate as defined in 130 CMR 501.013(A)(2) and 515.011(A)(2);

(iii) the individual is not being forced to sell the property by other devisees or heirs at law; and

(iv) at the time the Division first presented its claim for recovery against the deceased member's estate, the gross annual income of the person's family group, as defined in 130 CMR 501.001, was less than or equal to 133 percent of the applicable federal-poverty-level income standard for the appropriate family size.

(2) The waiver will be conditional for a period of two years from the date the Division mails notice that the waiver requirements have been met, or from the date that a court of competent jurisdiction determines that the waiver requirements have been met. If at the end of that period, all circumstances and conditions that must exist for the Division to waive recovery still exist, including meeting the same income standards under 130 CMR 515.011(D)(1)(b)(iv), and the real property has not been sold or transferred, the waiver will become permanent and binding. If at any time during the two-year period, the circumstances and conditions for waiver no longer exist, including meeting the same income standards under 130 CMR 515.011(D)(1)(b)(iv), or the property is sold or transferred, or the individual does not use the property as their primary residence, the Division will be notified and its claim will be payable in full.

(E) Outstanding Claims.

(1) For claims presented between April 1, 1995, and November 15, 2003, that are still outstanding, recovery will be waived if all requirements under the Division's then-existing regulations were met.

(2) For claims presented before April 1, 1995, a waiver for hardship did not exist.

(F) Fair-Market Value and Equity Value. If there will be insufficient proceeds from the sale or transfer of the property to satisfy the Division's claim in full, the fair-market value and equity value of all real property that is part of the deceased member's estate must be verified prior to the sale or transfer of said property.

(1) The executor or administrator of the probate estate or, in the case of real property that passes outside the probate estate, the person or entity to whom legal title or interest passed, must verify the fair-market value by sending to the Division a copy of the most recent tax bill or the property tax assessment that was most recently issued by the taxing jurisdiction, provided that this assessment is not one of the following:

- (a) a special-purpose assessment;
- (b) based on a fixed-rate-per-acre method; or
- (c) based on an assessment ratio or providing only a range.

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(2) The executor or administrator of the probate estate or, in the case of real property that passed outside the probate estate, the person or entity to whom legal title or interest passed, must also provide a comparable market analysis or a written appraisal of the property value from a knowledgeable source. A knowledgeable source includes one of the following: a licensed real-estate agent or broker, a real-estate appraiser, or an official from a bank, savings or loan association, or similar lending organization. The knowledgeable source must not have any real or apparent conflict-of-interest relationship with the estate.

(3) The Division may also obtain an assessment from a knowledgeable source.

515.012: Real Estate Liens

(A) Liens. A real estate lien enables the Division to recover the cost of medical benefits paid or to be paid on behalf of a member. Before the death of a member, the Division will place a lien against any property in which the member has a legal interest, subject to the following conditions:

- (1) per court order or judgement; or
- (2) without a court order or judgement, if all of the following requirements are met:
 - (a) the member is an inpatient receiving long-term or chronic care in a nursing facility or other medical institution;
 - (b) none of the following relatives lives in the property:
 - (i) a spouse;
 - (ii) a child under the age of 21, or a blind or permanently and totally disabled child; or
 - (iii) a sibling who has a legal interest in the property and has been living in the house for at least one year before the member's admission to the medical institution;
 - (c) the Division determines that the member cannot reasonably be expected to be discharged from the medical institution and return home; and

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(d) the member has received notice of the Division's determination that the above conditions have been met and that a lien will be placed. The notice includes the member's right to a fair hearing.

(B) Recovery. If property against which the Division has placed a lien under 130 CMR 515.012(A) is sold during the member's lifetime, the Division may recover all payment for services provided on or after April 1, 1995. This provision does not limit the Division's ability to recover from the member's estate in accordance with 130 CMR 515.011.

(C) Exception. No recovery for nursing-facility or other long-term-care services may be made under 130 CMR 515.012(B) if the member:

- (1) was institutionalized;
- (2) notified the Division that he or she had no intention of returning home; and
- (3) on the date of admission to a long-term-care institution had long-term-care insurance whose coverage met the requirements of 130 CMR 515.014 and the Division of Insurance regulations at 211 CMR 65.09(1)(e)(2).

(D) Repayment Deferred.

(1) In the case of a lien on a member's home, repayment under 130 CMR 515.012 is not required while any of the following relatives are still lawfully living in the property:

(a) a sibling who has been living in the property for at least one year before the member's admission to the nursing facility or other medical institution; or

(b) a son or daughter who:

(i) has been living in the property for at least two years immediately before the member was admitted to a nursing facility or other medical institution;

(ii) establishes to the satisfaction of the Division that he or she provided care that permitted the parent to live at home during the two-year period before institutionalization; and

(iii) has lived lawfully in the property on a continual basis while the parent has been in the institution.

(2) Repayment from the estate of a member that would otherwise be recoverable under any regulation is still required even if the relatives described in 130 CMR 515.012(D) are still living in the property.

(E) Dissolution. The Division will discharge a lien placed against property under 130 CMR 515.012(A) if the member is released from the medical institution and returns home.

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(F) Verification. The applicant or member must cooperate in providing verification as to whether the conditions under 130 CMR 515.012(A) exist, and in providing any information necessary for the Division to place a lien.

(G) Recording Fee. The Division is not required to pay a recording fee for filing a notice of lien or encumbrance, or for a release or discharge of a lien or encumbrance under 130 CMR 515.012.

515.013: Voter Registration

(A) Voter registration application forms are available through Division of Medical Assistance MassHealth Enrollment Centers and outreach sites to applicants and members who are (a) U.S. citizens, and (b) aged 18 or older, or who will be aged 18 on or before the date of the next election, in accordance with the National Voter Registration Act of 1993.

(1) Applicants and members will be:

- (a) informed of the availability of voter registration forms at application, at the time of an eligibility review, and when there is an address change;
- (b) offered assistance in completing the voter registration application form; and
- (c) able to submit voter registration application forms, in person or by mail, to the Division of Medical Assistance for transmittal to the proper election offices.

(2) Division staff will not:

- (a) seek to influence an applicant's or member's political preference or party registration;
- (b) display any political preference or party allegiance to the applicant or member;
- (c) make any statement to an applicant or member or take any action intended to influence the applicant's or member's decision regarding voter registration; and
- (d) make any statement to an applicant or member or take any action intended to lead the applicant or member to believe that the decision to register or not has any bearing on the availability of services or benefits.

(B) Completed voter registration application forms that are submitted to the Division of Medical Assistance will be transmitted to the proper local election office for processing within five days of receipt.

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515.014: Long-Term-Care Insurance Minimum Coverage Requirements for MassHealth Exemptions

For purposes of the financial eligibility exemption under 130 CMR 520.007(G)(8)(d), concerning treatment of the former home as an asset; and the exemption under 130 CMR 515.011(B) and 515.012(C), concerning repayment of assistance provided for nursing facility and other long-term-care services (hereafter collectively referred to as “MassHealth exemptions”), a long-term-care insurance policy must provide certain minimum coverage requirements as determined by the Division of Insurance.

(A) Under Division of Insurance regulations at 211 CMR 65.09(1)(e)(2), to qualify for the MassHealth exemptions, an individual must be a covered person under an individual, group, or employment-based group policy issued on or after March 15, 1999, that meets the individual policy minimum standards of 211 CMR 65.05 and all of the following requirements.

- (1) Scope of Benefits. The policy must cover nursing and custodial care in a nursing facility licensed by the Department of Public Health.
- (2) Daily Dollar Benefits. The policy must have available benefits of at least \$125 per coverage day in a nursing facility, except where the actual expense incurred is less, regardless of whether accrued benefits are measured in terms of days or dollar amount.
- (3) Nursing Facility Coverage Days: Lifetime Benefit Period. The policy must have benefits available sufficient to cover at least 730 days in a nursing facility.
- (4) Elimination Period. No policy may have an elimination period (days on which services are provided to an insured before the policy begins to pay benefits) longer than 365 days in a nursing facility. The application of more than one elimination period is not allowed unless the insured has received no benefits for a period of at least 180 consecutive days. In lieu of an elimination period, the policy may have a deductible of no more than \$54,750.

(B) All policies issued prior to March 15, 1999, need only comply with the minimum standards of 211 CMR 65.05, and the limitations and exclusion provision of 211 CMR 65.06, that were effective from April 1, 1989, through September 2, 1999.